STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

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F0000	This visit was for the Investigation of Complaint IN00107593 and Complaint IN00108414. Complaint IN00107593- Substantiated, Federal/State deficiencies related to the allegations are cited at F314. Complaint IN00108414- Substantiated, Federal/State deficiencies related to the allegations are cited at F323. Survey dates: May 22 and 23, 2012 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Survey team: Anne Marie Crays, RN Census bed type: SNF: 8 SNF/NF: 78 Total: 86 Census payor type: Medicare: 11 Medicaid: 68 Other: 7 Total: 86	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post-survey re-visit on or after June 12, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 30, 2012 by Bev Faulkner, RN			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident with a pressure ulcer received appropriate treatment to the area, in that Santyl, a debriding agent, was applied to a Stage II area; and weekly wound assessments were not completed, resulting in a Stage III pressure area on a resident's left hip (Resident D); and failed to ensure resident's skin was assessed at readmission, and treatment restarted to a previous right upper thigh pressure ulcer (Resident C), for 2 of 3 residents reviewed withe pressure ulcers, in a sample of 5. Resident C and D Findings include: 1. On 5/22/12 at 12:40 P.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Resident D had a wound on his left hip and on the	F0314	F314 Treatment/SVCS to Prevent/Heal Pressure Sores It is the policy of the facility to ensure that a resident of the facility that enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D's skin has been assessed and staged appropriately. Resident D is currently receiving care and treatment as recommended by the physician. Resident D has received weekly skin	06/12/2012

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	sides of his feet, and was not interviewable. Resident D was observed lying abed on an air mattress at that time. On 5/23/12 at 9:45 A.M., a skin assessment was requested. Physical Therapist Assistant [PTA] # 1 removed a dressing off of the resident's left hip. A pressure area was observed on the hip. The wound bed was covered in yellow slough, and slight redness surrounding the wound. PTA # 1 indicated it was a Stage III wound. PTA # 1 indicated, "It looks cleaner." The clinical record of Resident D was reviewed on 5/23/12 at 10:10 A.M. Diagnoses included, but were not limited to, history of CVA (stroke), coronary artery disease, and chronic kidney disease. A Physician's order, dated 2/25/12, indicated, "Apply PeleVerus Cream to [left] hip q [every] shift til healed." There was no documentation in the nurses' notes to indicate the reason for the order for a skin treatment. There was no skin assessment sheet for this date to indicate an assessment of the area. A "Pressure Wound Risk Assessment," dated 3/1/12, indicated: "Does the resident have impaired or decreased		assessments by a licensed nurse. Resident C no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A skin assessment has been completed for all residents in the facility on 5/24/12 by nurse managers to identify any pressure areas. If a pressure area was found or had already been identified, the IDT team reviewed the area for appropriate assessment, staging, and treatment. Licensed nurses and nurse managers have been re-educated on wound staging and on completion of weekly skin assessments by Nurse Consultant/DNS by 6/12/12. Certified nurse aide have been re-educated on reporting skin concerns and wound prevention by SDC/designee by 6/12/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nurses will complete a skin assessment upon admission/readmission.	

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	mobility? 'Yes.' Does the resident slide down in chair or bed? 'Yes'...Does the resident have urinary or bowel incontinence? 'Yes.' Is the resident confused...? 'Yes'...If any answer above is 'Yes,' the resident is at risk for developing skin breakdown...." Nurses Notes, dated 3/4/12 at 1:30 A.M., indicated, "The resident has an open area measuring 2.2 cm x 1.4 cm on his left hip. The MD line was called and an order was received for Allevyn with santyl [a debriding agent] changed every day. Will continue to monitor." A Physician's order, dated 3/11/12, indicated, "Resident has a pressure ulcer on his left hip a few centimeters from a previously found ulcer. The new one measures 2.0 cm x 1.8 cm. Please use a larger (5 x 5) Allevyn pad to cover both sores and apply Santyl cream. Change each shift and PRN [as needed] for dislodgement." An Interdisciplinary [IDT] Progress Note, dated 3/11/12, indicated, "IDT note R/T [related to] wound on [left] hip. Res. [resident] has 2 areas that have small amount yellow slough. Area [sic] are Stage II. Treatment ordered on 3/4/12 and change on 3/10/12. Santyl cover [with] allevyn q shift. Res. is on pressure		A second charge nurse will verify the initial skin assessment on new admissions/readmissions within 24 hours of admission. Skin assessments are being audited by ADNS/designee weekly for completion, accuracy, and initiation of appropriate interventions when needed. Nurse's managers are completing skin sweeps throughout facility twice monthly X 3 months, then monthly thereafter. Licensed nurses are completing skin assessments weekly, any new pressure areas or changes are reported to DNS/designee and appropriate orders and interventions are initiated. Any non-compliance with plan of correction can result in disciplinary action up to and including termination. DNS/designee will monitor compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the DNS/Designee is responsible for the completion of the wound CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is	

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	relieving mattress. Up in Broda chair. Res has very bony hips...." An Interdisciplinary Progress Note, dated 3/22/12, indicated, "IDT wound rounds this date. Wound [left] hip wound clean with [no] slough present. 2nd wound is closed...New treatment order for Allevyn change daily until healed...." A Nurses Note, dated 3/22/12 and untimed, indicated, "Area St [stage] 2 on lower [left] hip is closed...area St. 2 on [left] hip is smaller in size, no yellow slough noted. Wound is red. New order [physician], D/C [discontinue] previous treatment. N/O [new order] Allevyn to left hip daily until resolved [sic]...." A Physician's order, dated 3/22/12, indicated: "DC previous treatment to [left] hip wounds. Start Allevyn to wound on [left] hip. Change daily and PRN [as needed] dislodgement/soilage..." A treatment record, dated 3/12, indicated weekly skin assessments were initialed as completed on 3/2, 3/9, 3/16, 3/23, and 3/30. The treatment record indicated: "3/23/12 Allevyn to St. 2 on left hip daily [and] prn soilage," and was initialed as completed 3/23 though 3/31. A Pressure Wound Skin Evaluation		not achieved an action plan will be developed to ensure compliance. -Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. **Compliance date:** June 12, 2012	

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	Report indicated: "Wound present on admission: 'No,' Date Wound Developed: 3-11-12 (measured), [Left] hip boney [sic] prominence (lower)." Measurements were documented on 3/11 and 3/19. A notation, dated 3/22/12, indicated, "Blanches closed healed." A treatment record, dated 4/12, indicated, "Allevyn gentle 4 x 4 Apply with Santyl once daily to open area on left hip until healed," and was initialed as completed from 4/1 through 4/12. A notation indicated, "DC'd Healed, Rewritten." The same order, including the Santyl, was rewritten on 4/16, and initialed as completed from 4/16 through 4/30. Documentation regarding the resident's left hip wound was lacking from 3/22/12 until 5/4/12. A Wound Skin Evaluation Report indicated, "...[Left] hip, Date 5/4/12, Pressure ulcer, Length 3.5 cm, Width 6.5 cm, Depth 0...Color Black, Drainage minimal...." A Physician's order, dated 5/4/12, indicated, "PT [physical therapy] services for wound healing debridement and appropriate modalities on [left] hip...Santyl with allevyn on all 3 areas...."			

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	A Physician's order, dated 5/4/12 at 6:00 P.M., indicated, "Physical therapy evaluate [and] tx [treat]...for E-stim to wound at left hip, MIST 3x/wk to left hip...." The most recent assessment, dated 5/20/12, indicated, "Type, pressure, Length 4.0 in diameter, Depth <0.1, Color black, Drainage, minimal....Encircled area red." On 5/23/12 at 4:15 P.M., during interview with the DON and ADON, the DON indicated she had only been at the facility for 2 weeks, and was unaware of this resident previously. The DON indicated if a pressure ulcer has slough, it would not be a Stage II. The DON indicated herself, the ADON, and Medical Records staff were unable to locate any skin sheets from 3/22/12 until 5/4/12. The DON indicated she did not know if Santyl was being applied to the left hip wound inappropriately. The ADON indicated she thought the left hip wound was healed on 3/22/12, and then reopened on 5/4/12. 2. The closed clinical record of Resident C was reviewed on 5/22/12 at 3:00 P.M. Diagnoses included, but were not limited to, quadriplegia. A Minimum Data Set [MDS] assessment,			

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	dated 2/7/12, indicated the resident required total dependence of two + staff for bed mobility, transfer, toilet use, and bathing. The MDS assessment indicated the resident did not have any current pressure ulcers, but was at risk for developing pressure ulcers. A care plan, dated 2/27/12, indicated, "Problem, Resident has impaired skin integrity: rt [right] upper inner thigh." The Approaches included: "Assess wound weekly documenting measurements and description...Observe for signs of infection...3/20/12 PT [physical therapy] for mist therapy to [right] ischial wound and cover [with] allevyn." A Physician's order, dated 3/5/12, indicated, "...Mist therapy daily, Change allevyn after mist therapy. May change allevyn as needed for soilage and dislodgement." A "Summary of Weekly Wound Progress," dated 3/28/12, indicated, "...Short description: right posterior buttocks weekly wound assessment...Size 3.7 cm x 2.6 cm . 0.2 cm...Wound odor slight...Peri wound Intact...." A Physician's order, dated 4/2/12, indicated, "Continue Physical therapy 3x/wk x 30 days for Mist therapy [and]			

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	bed mobility...Care Plan Update, Problem, Wound [right] post. [posterior] buttocks...." A "Pressure Wound Skin Evaluation Report" indicated: "Right Isheal [sic] [lower]...4/2/12, Stage II, Length 3.5 [cm: centimeters], width 2.6 [cm], Depth 0.2 [cm]...Drainage scant...Mist therapy/Allevyn. 4/9/12, Hosp." The resident was transferred to a psychiatric hospital on 4/9/12, and returned to the facility on 4/17/12. Hospital transfer orders included, "...Mycolog...Apply topically to skin around duoderm on Rt. [right] thigh 2 times a day." That order was not transcribed to the facility admission orders. An order restarting the Allevyn to the right thigh was lacking. Physician orders regarding treatment to the right thigh pressure ulcer were lacking. An admission nursing assessment, dated 4/17/12 at 4:00 P.M., indicated, "Abrasion to [right] buttock." Measurements of the area were lacking. Documentation regarding the resident's right thigh pressure area was lacking until 4/23/12. A "Home Discharge Instruction" sheet, signed by the ADON, indicated,			

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	"Wound Tx [treatment] [Right] isheal [sic] apply Allevyn change every 3 days et [and] PRN [as needed]." A treatment record, dated 4/12, indicated, "Weekly Skin Assessments." A box, dated 4/9/12, indicated "Hosp," and boxes dated 4/16 and 4/23 were blank. A hospital history and physical, dated 4/24/12, indicated, "...Chief Complaint(s): Pressure ulcer wound to his right thigh...presents to [hospital] with complaints of a right leg wound. Patient had been living at North Park Nursing Home...He was recently discharged, on 4/23/12...he was at the house, getting him cleaned up and bathed, when he noticed a wound to his right inner thigh. He said the nursing home had told him that there was a small scratch on his right thigh, but there were no wounds. The wound did have a yellowish drainage, with positive odor...Patient does have a right thigh wound that measures 5 centimeters x 7.5 centimeters open wound with a 14 c 9.5 centimeter excoriation...." On 5/23/12 at 2:00 P.M., during interview with the ADON, she indicated when a resident is admitted or readmitted to the facility, a full body assessment should be completed and if there are any areas, a skin sheet should be filled out.			

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	On 5/23/12 at 2:40 P.M., during interview with the ADON, she indicated she discussed the discharge instructions with the resident's family on 4/23/12, but was unaware of who wrote the notation regarding the wound treatment of Allevyn. On 5/23/12 at 4:15 P.M., the DON indicated she was unable to find skin sheets or further documentation indicating the resident's pressure ulcer was treated from 4/17/12 until 4/23/12 at his discharge. 3. Stages of Pressure Ulcers, AMDA - 2008, included: Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Note: This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of			

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	the ulcer bed. Often includes undermining and tunneling. 4. On 5/23/12 at 2:40 P.M., the Administrator provided the current facility policy on the "Skin Management Program," dated 3/10. The policy included: "...A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and documented on the 'nursing admission assessment.' Alterations in skin integrity will be reported to the physician and family member(s). Physician orders will be obtained for all alterations in skin integrity identified. All alterations in skin integrity will be documented in one of two skin evaluation reports...The licensed nurse will notify the wound nurse of any alterations in skin integrity. The facility assigned wound nurse will complete a further evaluation of the wounds identified...The care plan will be initiated to include specific alterations in skin integrity...Weekly skin assessments will be completed on all residents with or without alterations in skin integrity and documented on the weekly skin assessment form and/or nursing notes...All alterations in skin integrity will be documented in one of two skin evaluation reports...The IDT [interdisciplinary] team will do rounds on a weekly basis to assess all wounds...."			

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	This Federal tag relates to Complaint IN00107593. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident received proper assistance when being transported in a wheelchair, causing the resident to fall, for 1 of 3 residents reviewed for falls, in a sample of 5. Resident B Findings include: On 5/22/12 at 12:40 P.M., during the initial tour, the Assistant Director of Nursing [ADON] indicated Resident B had fallen recently. The ADON indicated Resident B was not interviewable. The clinical record of Resident B was reviewed on 5/22/12 at 2:00 P.M. Diagnoses included, but were not limited to, Alzheimer's disease, osteoporosis, and anxiety. A Minimum Data Set [MDS] assessment, dated 12/23/11, indicated the resident had a short-term and long-term memory problem, and was moderately impaired in cognitive skills for daily decision-making.	F0323	**F323 Incident/Accidents** It is the policy of the facility that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** -Resident B continues to utilize wheel chair foot rests during wheel chair locomotion. -CNA educated at the time of incident by nurse regarding importance of safe transfer and approach. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** -Residents that require	06/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	05/23/2012

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	The MDS assessment indicated Resident B required extensive assistance of one staff for transfer and locomotion off of the unit, and limited assistance of one staff for locomotion on the unit. A care plan, dated 4/21/11, indicated: "Problem, Self care deficit related to d/t [due to] impaired cognition r/t [related to] dx [diagnosis]: alzhiemer's [sic] dementia." The Approaches included: "Assist with transfer to wheelchair, recliner, etc. as tolerated...Task segmentation as indicated...." Nurses Notes included the following notations: 2/4/12 at 7:50 P.M.: "CNA was pushing res [resident] in w/c [wheelchair] et [and] res placed both feet firmly on the floor. CNA cont [continued] to push et said pick up your feet [Resident B]. Staff saw res when she fell out of the w/c onto the floor hitting her head...Edema noted on [upper] [right] brow bone...Light blue bruise noted [right] brow meas [sic] 2.0 cm x 1.5 cm." 2/4/12 at 8:30 P.M.: "Spoke [with] CNA re: the importance of safe transfer et approach res if they place feet on the floor to make sure feet are securely lifted. States she understands."		assistance with locomotion in a wheelchair have the potential to be affected by the alleged deficient practice. -Staff has been re-educated on taking precautions when wheeling residents in a wheelchair by SDC/designee by 6/12/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** -Therapy will review residents requiring assistance with locomotion in wheelchairs to ensure that foot rests are utilized when appropriate. Therapy will continue to review upon admission, quarterly and as needed. -DNS/Designee will complete safe wheelchair locomotion CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	An Interdisciplinary Progress Note, dated 2/6/12 and untimed, indicated, "...Res was positioned in w/c, CNA was pushing her in w/c down hall when res. put feet down on floor, and res. fell forward out of w/c hitting her head on [right] side. Res was placed back in her w/c, and cool cloth applied to head. IDT [interdisciplinary team] intervention is to place leg rests on w/c to support LE's [lower extremities] during transport. CNA was also educated that res feet not be on floor during transport...." On 5/23/12 at 4:15 P.M., during interview with the Director of Nursing, she indicated the facility did not have a current policy on how to safely transport residents. This federal tag relates to Complaint IN00108414. 3.1-45(a)(2)		To ensure compliance, the DNS/Designee is responsible for the completion of the safe wheelchair locomotion CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance -Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. **Compliance date:** June 12, 2012	

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